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EXAMINING THE AVAILABILITY OF SAFE KITS

AT HOSPITALS IN THE UNITED STATES

WEDNESDAY, DECEMBER 12, 2018

House of Representatives,

Subcommittee on Oversight

and Investigations,

Committee on Energy and Commerce,

Washington, D.C.

The subcommittee met, pursuant to call, at 10:00 a.m., in Room 2123, Rayburn House Office Building, Hon. Gregg Harper [chairman of the subcommittee] presiding.

Present: Representatives Harper, Griffith, Burgess, Brooks, Walberg, Costello, Carter, Walden (ex officio), DeGette, Castor, Clarke, Ruiz, Peters, and Pallone (ex officio).

Staff Present: Jennifer Barblan, Chief Counsel, Oversight and Investigations; Karen Christian, General Counsel; Ali Fulling, Legislative Clerk, Oversight and Investigations, Digital Commerce and Consumer Protection; Brighton Haslett, Counsel, Oversight and Investigations; Zach Hunter, Director of Communications; Sarah Matthews,

Press Secretary, Energy and Environment; Jeff Carroll, Minority Staff Director; Chris Knauer, Minority Oversight Staff Director; Jourdan Lewis, Minority Policy Analyst; Perry Lusk, Minority GAO Detailee; Andrew Souvall, Minority Director of Communications, Outreach and Member Services; and C.J. Young, Minority Press Secretary.

Mr. Harper. The subcommittee will come to order.

Today, the subcommittee on Oversight and Investigations is holding a hearing entitled "Examining the Availability of SAFE Kits at HOSPITALS in the United States."

Sexual assault is a vicious and deeply traumatizing crime inflicted against hundreds of thousands of Americans each year. As policymakers, it is our responsibility to do everything we can to help those survivors and hold the perpetrators of those crimes accountable. To accomplish that, we must improve and expand access to critical forensic and healthcare services that survivors seek after an assault.

In 2016, the Bureau of Justice Statistics reported that more than 323,450 people were the victims of sexual assault. However, the actual number of survivors may be much higher. According to the National Crime Victimization Survey, sexual assault is the most underreported crime in the country. In fact, aggregate data from the FBI and DOJ indicates that only 23 percent of rapes were reported between 2012 and 2017.

The first step towards prosecuting these vicious crimes is often the collection of a sexual assault forensic exam or commonly known as a rape kit. A rape kit can be performed by a specially trained sexual assault nurse examiner, a SANE, or by a nurse or medical professional that does not have SANE training. However, rape kits performed by trained SANEs, what we shall call SAFE kits, result in better outcomes for patients, including shortened exam time, better quality healthcare, higher quality forensic evidence collection, and certainly higher prosecution rates.

These kits can be vital to securing a prosecution and conviction. But in many areas of the country, it can prove shockingly difficult for a survivor of sexual assault to obtain a SAFE kit. One of our witnesses today, the International Association of Forensic Nurses, estimates that only about 15 percent of hospitals in the United States provide SAFE kits. We don't know what happens to many of the survivors that visit a hospital

that do not have SANE nurses available.

In 2016, the GAO published a report entitled Sexual Assault: Information on Training, Funding, and Availability of Forensic Examiners. The report examined the challenges that hospitals face in providing access to SANEs and SAFE kits, including limited availability of SANE training, weak stakeholder support for examiners, and low examiner retention rates. We need to explore each of these issues today.

Over the course of our work, we sent letters to 15 hospitals and 10 hospital associations across the country to assess what services those hospitals offer and what challenges they face in making those services available. Their responses were enlightening, and have not only helped the committee better understand the challenges to provide access to SANEs and SAFE kits, but also identifies some of the solutions.

I want to thank all of those hospitals and groups for their assistance. And without objection, I ask unanimous consent to enter these 25 responses to the committee's letters into the record.

Without objection, they are so entered.

[The information follows:]

\*\*\*\*\* COMMITTEE INSERT \*\*\*\*\*

Mr. Harper. Finally, adding to the issue of lack of access is the fact that very little data is available about where survivors can find SAFE kits. The nationwide database compiled by the Forensic Nurses appears to be the best in the country, but it is not comprehensive. For example, the database lists only two locations in my home State of Mississippi, but my staff was able to locate at least 10 SANE programs online. That is not a criticism at all of the Forensic Nurses, but a call to action. And I hope that one result of today's hearing will be to motivate communities around the country to raise awareness of where SAFE kits can be found, and move towards making that information widely available.

To that end, I'd also like to ask unanimous consent to enter into the record a statement -- or a document that the committee created, which includes every list or database our staff could find for SANE programs and SAFE-ready facilities across the country.

Without objection, so entered.

[The information follows:]

\*\*\*\*\* COMMITTEE INSERT \*\*\*\*\*

Mr. Harper. I would also like to submit into the record a letter from the Joyful Heart Foundation about SAFE kits, which we received actually this morning.

Without objection, so entered.

[The information follows:]

\*\*\*\*\* COMMITTEE INSERT \*\*\*\*\*

Mr. Harper. It is our hope that this can be a resource to survivors across the country and that we can lead the charge in educating the public about this important issue.

I'd like to thank all of our witnesses for joining us in sharing your expertise and perspectives today. I know this is a very sensitive topic, but it's a very important one for our country, and we look forward to hearing your testimony shortly.

Before I introduce the ranking member for her statement, I would like to take a moment of personal privilege. This will be my last hearing chairing this subcommittee before I begin my eagerly anticipated retirement in a few weeks, not from work, just from Congress. I would like to thank Chairman Walden for the opportunity to chair this subcommittee through so many important hearings, including this one. And I would also like to thank the ranking member and all of my colleagues on both sides of the aisle for their assistance on so many important matters that face this committee and our country.

With that, I will yield to recognize Ranking Member DeGette.

[The prepared statement of Mr. Harper follows:]

\*\*\*\*\* COMMITTEE INSERT \*\*\*\*\*

Ms. DeGette. Thank you, Mr. Chairman.

And taking a moment of personal privilege myself, I will say that it's been a real privilege to work with you as the chairman. This is a venerable committee of Energy and Commerce. I think it's the best subcommittee in the House, and I'm really happy that you got the opportunity to chair it.

We've had a number of really solid and important investigative hearings. I think it's really fitting and a reflection on you and your commitment to Americans that the last hearing that we're going to have is a hearing about keeping patients safe and getting the evidence we need.

So please join me, colleagues, in thanking the chairman for his wonderful service.

[Applause.]

Mr. Harper. Thank you so much.

Ms. DeGette. For a survivor of sexual assault, it's critical to protect people's health in the aftermath of an attack and to receive critical timely medical services that address the unique needs of each victim. Compassionate care and the diligent collection of evidence are essential for the victims' well-being and for the hopes for justice.

The Department of Justice estimates that, nationwide, over 160,000 people were raped or sexually assaulted in 2016, the last year for which we have data. Yet these crimes go woefully underprosecuted. According to the Rape, Abuse, and Incest National Network, only 230 out of 1,000 rapes are reported to the police. Forty-six out of 1,000 leads to an arrest. And only nine are ever referred to a prosecutor for trial.

One important tool for successfully treating and prosecuting sexual assault is to have a trained sexual assault examiner collect a wide variety of forensic evidence from the victim, and, of course, that's what's called a sexual assault evidence collection kit.



This kit include a victim's clothes, hair, blood, and saliva for DNA testing and analysis. DNA evidence significantly increases the likelihood of identifying a perpetrator, it increases the likelihood of holding the perpetrator accountable, and it can even prevent further assaults by identifying repeat offenders.

And, shockingly, though, if a victim shows up to a hospital after an assault today, it's far from guaranteed that she would be able to get a sexual assault examination, even if she knows to ask for one. In 2016, the GAO conducted a study assessing the availability of sexual assault forensic examiners nationwide. As part of this study, GAO found that only one of the 23 sexual assault programs in Colorado is large enough to have examiners available 24 hours a day, 7 days a week.

Furthermore, according to the GAO, officials in the six States they reviewed did not know exactly how many practicing examiners there were in their States. There was no national database of sexual assault examiners. And what databases did exist were often out of date and did not cover all of the settings where an exam might occur. This suggests to me that we must do more to get good data on our Nation's capacity for sexual assault examinations so we can then evaluate these programs and ensure they have the resources they need to serve victims.

Keep in mind, these are the barriers that exist just for getting a kit done in the first place. While not the focus of this hearing, there's also a huge backlog of kits that were either never sent to a crime lab to be tested or were sent to a lab but were left to linger for a period of months or longer. This is, to say the least, disturbing.

Today, I look forward to hearing from the witnesses about what we can do to train additional examiners to do this difficult but necessary work and also to retain the examiners that we do have. I also want to hear more about how successful sexual assault examination programs are built and what we can do to address the unique

challenges inherent in providing these services in rural areas.

I hope the committee can shed some light on these problems and find ways that will make it easier for any American to get a sexual assault kit from a trained examiner in a time that is admittedly a very emotionally stressful and difficult time for these victims.

And, finally, Mr. Chairman, I have to note the importance of the Violence Against Women Act. This act supports a number of programs that address health issues associated with sexual assault, including three grant programs that can be used to fund or train sexual assault forensic examiners.

Unfortunately, this law, which has enjoyed bipartisan support for over 20 years, is going to expire in a little over a week. We've got to act to reauthorize this law before the 115th Congress ends so that the programs can continue the important work they're doing and to make sure the victims get the care they need.

Thank you, and I yield back.

[The prepared statement of Ms. DeGette follows:]

\*\*\*\*\* COMMITTEE INSERT \*\*\*\*\*

Mr. Harper. The gentlewoman yields back.

The chair will now recognize the chairman of the full committee, Chairman Walden, for 5 minutes for the purpose of an opening statement.

Chairman Walden. Well, thank you very much, Mr. Chairman.

And I too want to thank you for your great leadership and service, your civil demeanor, your intellectual curiosity on the issues that have come before the Oversight Investigative Subcommittee, and the great way you've worked to get things done here. It really has made a difference for the country, and you've left the place far better than you found it. And so we thank you for your service and wish you Godspeed in doing your next bit of service with family and elsewhere. So thanks for all you've done, Gregg; you've done a great job. We really appreciate it.

And I want to follow up on Ms. DeGette's comments as well, because in September, I wrote to the Speaker, along with others, saying we need to reauthorize VAWA. It's very, very important to do. I've supported it every time. It's essential. And I think on this SAFE kits issue that we're dealing with today, this will be a perfect priority going forward, it would have been if we were in the majority first thing up in the next year, and I think we should be able to find common ground on this matter as well. And I greatly appreciate the witnesses coming today.

This is the last, I think, subcommittee hearing on Oversight, although in talking to some of my friends from the Senate, it appears they're going to come back the day after Christmas. So maybe we'll have time for another hearing, Mr. Harper, just before New Years or something. I thought I'd throw that out.

Over the past year, the committee has been investigating access to SANEs and SAFE kits at hospitals across the U.S., as you've heard. And throughout our investigation, we've spoken to more than 40 trauma Level I and II hospitals. Some of

these hospitals have very robust SANE programs that are well-equipped to provide the best care to survivors of sexual assault, including one of our witnesses today, Mount Sinai Health Systems. So we appreciate what you're doing.

Others, however, seemed ill-prepared to address the needs of sexual assault survivors. One hospital even asked a member of my staff, and I'm going to quote, "what is a rape kit," close quote. There are currently no Federal requirements regarding SANEs in the healthcare facilities. As is made clear in the responses to the committee's letters, some States and hospital associations have made great strides, while others have not put the same emphasis on the problem.

I'd like to commend hospitals in my home State of Oregon for being forthcoming and helpful in our push to expand access to services for survivors of sexual assault in communities urban and rural. Their partnership with the Oregon District Attorney Sexual Assault Task Force is an example of the work we hope to see spread across the Nation.

As Chairman Harper mentioned, we don't know what happens to many of the survivors that visit a hospital and are unable to obtain a SAFE kit. Some survivors may be forced to travel several hours to the nearest SAFE-ready hospital to obtain a kit. Others may simply return home and choose never to report this horrific crime.

There's currently no data or tracking of these trends at the Federal level; however, through the course of our investigation, we've spoken with several survivors who have faced just that situation. One survivor we spoke to, Leah Griffin, shared her experience of trying to get a SAFE kit in 2014 after being drugged and raped. When she went to her local hospital, she was told, quote, "we don't do rape kits here," close quote. The hospital told Leah that her options were to drive herself to another hospital or to pay out of pocket for an ambulatory transfer. Leah told us, and I quote, "I was so shocked, I just

went home."

Hours later, Leah drove to the other hospital to get a SAFE kit, where it was discovered that she had internal injuries. Ultimately, the prosecutors in Leah's case declined to bring charges because the delay in obtaining a rape kit meant the evidence in her case was weak. Leah asked herself, and again I quote, at her -- by the way, she allowed us to share her name -- "how do we have a justice system that demands empirical evidence from survivors of sexual assault and then denies access to that evidence collection?"

Leah's is not the only such story we've heard and read about; there's also Megan Rondini, Denicia Ball (ph), and unfortunately, many others. The day that an individual is sexually assaulted can be the worst day in her or his life. The thought of turning to a hospital after such a trauma and then being told, sorry, we can't help you, is unimaginable and, frankly, unacceptable.

These stories are heartbreaking. And, unfortunately, due to the lack of data and tracking within hospitals, we cannot estimate how many sexual assault survivors face this very same experience when they attempt to report these crimes.

I want to thank Leah and the other survivors we spoke to for sharing their experiences with us, I know that cannot have been easy, as well as those hospitals, hospital associations, and survivor advocacy groups that shared their expertise and experience with us over the course of this investigation. I hope that we can begin identifying some successful models that other hospital systems can apply to their own communities. And in particular, I hope the use of technology, such as online training programs and telehealth, can begin to solve the issues of access in our rural communities. Many health centers and hospitals in my district have a hard time recruiting healthcare professionals already, so expanding options for these communities is an extra challenge

that we have to take on.

And, finally, I want to thank Representative Poe, who is in the audience today, who has been a real leader on this, along with Mr. Griffith and others on the committee. But, Ted, we thank you for your leadership on this, and I know there's legislation that's being put together here that hopefully we can move before the end of the year, if we can get everybody on the same page.

Again, Mr. Chairman, thanks for your wonderful leadership on this and so many other topics. And I yield back the balance of my time.

[The prepared statement of Chairman Walden follows:]

\*\*\*\*\* COMMITTEE INSERT \*\*\*\*\*

Mr. Harper. The gentleman yields back.

The chair will now recognize the ranking member of the full committee, Mr. Pallone, for 5 minutes for the purposes of an opening statement.

Mr. Pallone. Thank you, Mr. Chairman.

Sexual assault is a horrific crime, and we must continue to work to end the cycle of violence. Sexual assault forensic examiners, otherwise known as SAFEs, play an important role in helping those who are victims of these crimes. SAFEs provide care to victims of sexual assault, and with the use of a forensic exam kit, can collect a wide variety of DNA evidence that can be used to prosecute an offender.

Thanks to the Violence Against Women Act, States must provide sexual assault kits free of charge to anyone who needs it. The law also authorizes three Department of Justice grant programs that fund and train sexual assault forensic examiners.

Despite the strides we've made in the last 20 years, it can still be quite difficult for a victim to find a trained examiner when they need one. For example, according to media reports, only one hospital here in the D.C. area has a program with sexual assault nurse examiners on staff. Unfortunately, the problem is occurring nationwide. For example, according to a 2016 report from the GAO, officials in the six States they studied said there were not enough examiners in their States to meet the demand for exams, particularly in rural areas.

In some States, entire counties do not have any SAFE programs available. In some cases, victims must travel over an hour to a facility with a trained examiner. In that time, a victim must avoid bathing, showering, using the restroom, or changing clothes, or else risk damaging the evidence before it can be collected. And this is unacceptable, and we must find ways to make these services more widely available.

The GAO report also found that there was no national database that captures the

number of examiners, where they are, and what their capabilities are. The only data available is limited in scope and collected on a voluntary basis. And this means that victims do not have to update information and cannot easily identify all healthcare settings where sexual assault forensic exams might be conducted. This kind of information should be easily accessible to victims in their most vulnerable moments,

Moreover, even when a facility provides these kits and related SAFE services, States and hospitals have struggled to retain enough examiners. State officials reported to GAO that they face challenges such as limited availability of classroom and clinical training, weak support for programs from stakeholders, and the emotional and physical demands on examiners. And taken together, these findings demonstrate the challenges we still face in ensuring that all victims of sexual assault can get access to a forensic exam kit and services provided by a trained examiner, should they request it.

This is not to say there are no success stories. Clearly, there are many hospitals and other facilities that provide sexual assault kits and SAFE services for those who need it, and we should learn from those cases and determine what we can replicate on a broader scale.

So I look forward to hearing from each of our witnesses here today about what we can do to get our arms around this problem and what we can do to expand and retain our workforce of trained sexual assault forensic examiners.

And, finally, I just would like to reiterate the importance of the Violence Against Women Act. This act is a critical part of the Federal Government's response to sexual assault and it funds many of the programs we'll be talking about today, but the law is set to expire in just over a week. We must ensure this act is reauthorized so that these critical programs continue to receive funding and victims can receive the care and services they need.



So I want to thank our panelists for sharing their expertise on this important issue as we move forward.

I yield back.

[The prepared statement of Mr. Pallone follows:]

\*\*\*\*\* COMMITTEE INSERT \*\*\*\*\*

Mr. Harper. The gentleman yields back.

I ask unanimous consent that the members' written opening statements be made part of the record. Without objection, will be entered into the record.

Additionally, we welcome non-Energy and Commerce Committee members who are with us today. Pursuant to House rules, members not on the committee are able to attend our hearings but not ask questions, and we've already recognized Representative Ted Poe from Texas, who is the only other member that I see, and that's just the way it is.

I would now like to introduce our witnesses for today's hearing. Today, we have Ms. Nicole Clowers, managing director of Health Care at the GAO. Next is Ms. Sara Jennings, president-elect of the International Association of Forensic Nurses. Then we have Ms. Lynn Frederick Hawley, executive director of the SAVI Program at Mount Sinai Hospital. And, finally, Ms. Kiersten Stewart, director of Public Policy and the Washington Office of Futures Without Violence.

As you are aware, the committee is holding an investigative hearing, and when doing so, has had the practice of taking testimony under oath. Do any of you have any objection to testifying under oath?

All witnesses have indicated no.

The chair then advises you that under the rules of the House and the rules of the committee, you are entitled to be accompanied by counsel. Do any of you desire to be accompanied by counsel during your testimony today?

All of the witnesses have indicated no.

In that case, if you would, please rise and raise your right hand and I will swear you in.

Do you swear that the testimony you are about to give is the truth, the whole truth, and nothing but the truth?

All the witnesses have anticipated -- have answered and responded in the affirmative.

You're now under oath and subject to the penalties set forth in Title 18, Section 1001 of the United States Code. You may now give a 5-minute summary of your written statement, and I will now first call on Nicole Clowers, managing director of Health Care for the U.S. Government Accountability Office.

You are recognized for 5 minutes, Ms. Clowers.

**TESTIMONY OF NICOLE CLOWERS, MANAGING DIRECTOR, HEALTH CARE, U.S. GOVERNMENT ACCOUNTABILITY OFFICE; SARA JENNINGS, RN, PRESIDENT-ELECT, INTERNATIONAL ASSOCIATION OF FORENSIC NURSES; LYNN M. FREDERICK HAWLEY, MA, EXECUTIVE DIRECTOR, SAVI PROGRAM, MOUNT SINAI HOSPITAL; AND KIERSTEN STEWART, DIRECTOR OF PUBLIC POLICY AND THE WASHINGTON OFFICE, FUTURES WITHOUT VIOLENCE**

**TESTIMONY OF NICOLE CLOWERS**

Ms. Clowers. Thank you.

Chairman Harper, Ranking Member DeGette, and members of the subcommittee, thank you for having me here today to discuss our 2016 report on the availability of sexual assault forensic examiners.

Studies have documented the benefits of using trained examiners in the cases of sexual assault. As the chairman noted, these benefits include shorter exam times, more comprehensive medical care, better health outcomes for the victims, better collection and documentation of the evidence, and higher prosecution rates. However, concerns have been raised about the availability of examiners to meet the need for exams.

To help inform today's discussion, I will summarize key findings from our 2016 report, which include what is known about the availability of sexual assault forensic examiners nationwide, as well as in selected States, as of 2016, and the challenges selected States face to maintaining a supply of sexual assault examiners.

With respect to the availability of examiners, we found that only limited nationwide data exist on the availability of sexual assault examiners; that is, both the

number of practicing examiners and the number of healthcare facilities that have examiner programs. While some national estimates are available, they are not comprehensive, as they only capture examiners with select certifications or program information that is voluntarily reported.

We also found limited information at the State level. While officials from all six States that we contacted were able to provide information on the number of examiner programs located within their States, only three could provide estimates of the number of practicing examiners. And the State data available at the time of our audit were likely incomplete, as only one of the six States had a system in place to formally track the number and location of examiners.

Despite these data limitations, officials in all six States told us that the number of examiners available in their State did not meet the need for exams, especially in rural areas. For example, officials in Wisconsin explained that nearly half of all the counties in the State do not have any examiner programs available. As a result, officials said victims may need to travel long distances to be examined by a trained examiner. The challenge of long travel distances can be further complicated for rural residents due to weather-related travel restrictions during certain times of the year.

Finally, we found that there are multiple challenges to maintaining the supply of examiners, including, one, the limited availability of training, which includes limited classroom, clinical, and continuing education training opportunities; two, low retention rates of examiners due to the emotional and physical demands of the job, coupled with low pay; and, three, weak stakeholder support for examiners, such as hospitals being reluctant to cover the cost of training or paying for examiners to be on call.

Officials told us about a number of strategies they have used to help address these challenges, such as web-based training and mentoring programs. For example,

officials in Colorado told us that an examiner program coordinator in an urban hospital provides volunteer, on-call technical assistance and clinical guidance to the examiners in rural parts of the State where those resources are not otherwise available.

Chairman Harper, Ranking Member DeGette, and members of the subcommittee, this completes my prepared statement. I would be pleased to respond to any questions at the appropriate time. Thank you.

[The prepared statement of Ms. Clowers follows:]

\*\*\*\*\* INSERT 1-1 \*\*\*\*\*

Mr. Harper. Thank you so much for your testimony.

The chair will now recognize Sara Jennings, RN -- and I'm partial to RNs since I'm married to one -- who is the president-elect of the International Association of Forensic Nurses.

You are hereby recognized for 5 minutes for testimony.

### **TESTIMONY OF SARA JENNINGS**

Ms. Jennings. Thank you.

Chairman Harper, Ranking Member DeGette, and members of the subcommittee, thank you for the opportunity to testify today. On behalf of the 4,300 forensic nurses who make up the membership of the International Association of Forensic Nurses, I am pleased to be here this morning in relation to the availability of SAFE kits at hospitals in the United States, and to discuss issues impacting patients' access to essential services following an assault. This is an important topic, and the IFN appreciates the active role of the committee to address it.

My name is Sara Jennings, and I'm a forensic nurse since 2006, and I'm the president-elect for the IFN. First, let me tell you a bit about forensic nursing. A forensic nurse is a registered nurse or advanced practice nurse who's received specialized education and training. Forensic nurses provide specialized care for patients who are experiencing acute or long-term health consequences associated with victimization or violence and/or have unmet evidentiary needs relative to having been victimized or accused of victimization. In addition, forensic nurses provide consultation and testimony for civil and criminal proceedings relative to nursing practice, care given, and opinions rendered regarding findings.

Since forensic nursing is a recognized nursing specialty of the American Association of Nurses, a person must first become a registered nurse before becoming a forensic nurse. Forensic nurses work in a variety of fields, including sexual assault, domestic or intimate partner violence, child abuse and negligent, elder maltreatment, human trafficking, death investigations, corrections, and in the aftermath of mass disasters. In the United States, forensic nurses most frequently work in hospitals, community anti-violence programs, coroners, or medical examiners' offices, corrections institutions, and psychiatric hospitals.

Sexual assault nurse examiners, or SANEs, are registered nurses who have completed specialized education and clinical preparation in the medical forensic care of the patient who has experienced sexual assault or abuse. To become a SANE you must first be a registered nurse with 2 years or more of experience in areas of practice, such as emergency department nursing. The same training should meet the IFN SANE educational guidelines and will consist of both classroom and clinical components.

The Bureau of Justice Statistics within the Department of Justice reports in its National Crime Victimization Survey for 2016 that there were 298,410 rapes or sexual assaults in the United States. There were also 1,068,120 incidents of domestic violence.

In March of 2016, the General Accountability Office issued a report investigating the availability of trained examiners on a national level. The report identified major flaws and survivor access to sexual assault examination services. Specifically, the report showed a disturbing lack, and in some cases a complete absence, of information and data on the number of sexual assault examiners in most States.

The IFN is pleased that Congress is increasingly aware of the problem and the need to ensure appropriate access to necessary services and supplies. Several bills have been introduced to try to address this problem. The IFN is supportive of the Survivors'



Access to Supportive Care, or SASCA, and also encourages efforts to improve the Violence Against Women Act. IFN strongly supports the SASCA, which was introduced in the Senate by Senator Patty Murray and Senator Lisa Murkowski.

IFN believes this bill would expand access to qualified examiner services and help strengthen national standards of care for survivors of sexual assault. SASCA would also provide guidance and support to States and to hospitals providing sexual assault examination services and treatment to survivors.

IFN also strongly supports the swift reauthorization of the Violence Against Women Act; however, IFN does believe that there are several key improvements that must be made to this law, including establishing a standardized national sexual assault evidence collection kit, requiring health insurance to be the primary payer, and establishing evidence-based, trauma-informed national medical forensic exam protocols for intimate partner violence. It is imperative for the long-term health and recovery of these patients that a standardized approach be developed and a plan for effective implementation.

Thank you for this opportunity to testify today, and I'm available at the appropriate time for questions.

[The prepared statement of Ms. Jennings follows:]

\*\*\*\*\* INSERT 1-2 \*\*\*\*\*

Mr. Harper. Thank you for your testimony.

The chair will now recognize Lynn M. Frederick Hawley -- that's Hawley, I'm sorry, my apologies.

Ms. Frederick Hawley. No problem.

Mr. Harper. -- executive director at SAVI Program at Mount Sinai Hospital.

And you're now recognized for 5 minutes.

### **TESTIMONY OF LYNN M. FREDERICK HAWLEY**

Ms. Frederick Hawley. Thank you.

Good morning. Chairman Harper, Ranking Member DeGette, and members of the committee, thank you for the opportunity to testify before you today. I would also like to acknowledge Representative Tonko and Representative Clarke from New York.

My name is Lynn Frederick Hawley. I am the executive director of the Sexual Assault and Violence Intervention Program of the Mount Sinai Hospital, otherwise known as SAVI. Makes it easier for you to say it. Founded in 1852, the Mount Sinai Hospital is one of the Nation's largest and most respected hospitals, acclaimed internationally for excellence in clinical care. Ranked among the top hospitals nationwide, we serve one of the most diverse populations in the world as well.

It has been a priority at the Mount Sinai Hospital for decades to maintain a comprehensive program to address the needs of sexual assault survivors. Our goal is to provide the highest quality medical care and compassionate client-centered services to address both the patient's physical and psychological trauma. We believe it's critical to validate, heal, and empower survivors and their supporters to lead safe, healthy lives through advocacy, free and confidential therapy and counseling, and education.

The Mount Sinai Hospital is one of the few institutions with a dedicated program exclusively focused on providing outreach, comprehensive training, emergency department advocacy, and counseling services to address the needs of past and present victims of sexual assault and intimate partner violence. SAVI was founded in 1984, and we have grown exponentially in the past 34 years to meet the evolving needs of survivors and our communities, including creating our sexual assault forensic examiner program.

I should emphasize that this evolution has been made possible by the support of Mount Sinai leadership, the availability of funding for this kind of programming, and the backing of the communities we serve. We work very intensively with our community. Our sexual assault forensic examiner program has been designated a center of excellence since 2006 by the New York State Department of Health.

In addition to the SAFE program, we maintain over 150 highly trained volunteer advocates who are certified and go on call 24/7 to respond to all instances of sexual assault in our hospitals. The advocates, together with the trained SAFE clinician, work seamlessly to provide comprehensive services to the sexual assault survivors seeking care at the Mount Sinai Hospital. SAVI therapists are then available to support the survivor beyond the immediate crisis services received in the emergency department.

Specifically, the Mount Sinai Hospital and its affiliate medical school, the Icahn School of Medicine at Mount Sinai, employ 24 medical professionals who have decided to take the additional steps to become a SAFE examiner with the SAVI program. Currently that includes 10 nurses, 7 physicians assistants, and 7 physicians, including residents. All are employed by the Mount Sinai Hospital in other capacities, they are then screened by SAVI for this particular role, have completed extensive additional 40-hour training to qualify as a SAFE, and then they complete a preceptorship with our program specifically. Many of the SAFE-trained staff work in the emergency department, and they are able to

provide services to a patient if the on-call SAFE clinician, for whatever reason, is unexpectedly unavailable.

I would like to take you through the protocol quickly for treating survivors of sexual violence in our program. As an initial matter, we have a strong protocol in place for clinicians and staff to identify potential survivors of sexual assault and respond sensitively. Once a patient discloses sexual assault, they are triaged to a private, safe equipped room. Both the on-call SAFE and the SAVI advocate are contacted to come to our hospital to provide care and treatment to the patient.

The advocate is a certified volunteer who provides counseling, support, information, referral, advocacy, safety planning to the survivor and any family member or supportive person who is there. The advocate remains with the survivor throughout their stay in the hospital. The SAFE conducts the medical and evidence collection exam consistent with the patient's consent and their wishes.

Specific medical protocols and regimens are followed in the event the survivor is a candidate for a variety of prophylaxis treatment. The patient receives detailed discharge instructions and treatment counseling options, including followup for any medical care or continued prescriptions they need.

SAVI follows up with every patient after they have spent time in the emergency department. We also work closely with the NYPD and with our security department in the event that the survivor hasn't yet let the kit go over to the police department.

In order to provide this multilayered response, many resources must be invested. This is not care that survivors should be expected to underwrite. None of SAVI services, including our SAFE program, generate income. So it's the vision of an institution like Mount Sinai that sees the overarching benefit and necessity of providing the care to survivors and provides the context in which it can happen, as well as the

availability/accessibility of funding from our city, State, Federal, and community partners that makes this even possible.

On that note, 36 seconds over, I'll be quiet, and I'm happy to answer any questions as we go forward.

[The prepared statement of Ms. Frederick Hawley follows:]

\*\*\*\*\* INSERT 1-3 \*\*\*\*\*

Mr. Harper. The chair wants to thank Ms. Frederick Hawley, the executive director of the SAVI program at Mount Sinai Hospital, for your testimony.

And the chair now recognizes Kiersten Stewart, who's the director of public policy and the Washington Office for Futures Without Violence.

### **TESTIMONY OF KIERSTEN STEWART**

Ms. Stewart. Thank you, Mr. Chairman, thank you, Ranking Member DeGette, and thank you members of the committee for your leadership in paying attention to this issue. I would also like to call out Congresswoman Clarke and Congresswoman Castor, who, along with Mrs. Walters and Mr. Costello, recently introduced the Violence Against Women Health Act, which will also make progress on this goal.

For those of you who do not know FUTURES, we are a national nonprofit organization that works to end violence against women and children here in the U.S. and around the world. We also house the National Health Resource Center on violence against women. Less well known is that our work actually began -- we began as an organization about 35 years ago simply with a chair in an emergency room at San Francisco General Hospital, trying to provide whatever help we could to every woman who came in a victim of violence. I'm proud to say we've progressed since then, but the mission remains the same.

Some things to understand. Please know that sexual assault is painfully common and a crime largely committed against young people. More than 80 percent of rapes are committed against those under the age of 25, and about half of those are committed against those under the age of 18, children. While young girls and women are those most likely to be victims of rape and sexual assault, men and boys are also victims, as are

individuals who do not always fit our traditional norms of male and female.

American Indian and Alaska Native women, people who live in rural areas, as well as individuals with disabilities, also experience higher rates of sexual violence. As we analyze who has access to forensic exams, as well as all healing services for sexual violence, it is important to keep in mind the needs of all victims.

The consequences of sexual violence are often severe and often long lasting. While different people respond differently to sexual violence, sexual violence often leaves a deeply painful mark that some never fully heal from. New economic estimates also create a staggering picture of the cost associated with rape. Using 2014 dollars, the estimated lifetime cost of rape at a population level is nearly \$3.1 trillion. This is based on the fact that 25 million Americans have been raped.

The government, our tax dollars, pay an estimated \$1 trillion, or about a third of that lifetime economic burden. These numbers do not capture the personal pain of rape and sexual assault on individuals or their families, but they do create a call for action.

Forensic examines, as you've heard, help improve prosecution of sexual assault, but training is essential. I will not duplicate the testimony you've heard from others, but we can't just view training as a one-off act. It needs to be integrated into broader hospital quality improvement measures, attention needs to be paid to the vicarious trauma often experienced by the nurse examiners, and training needs to engage the entire health entity, from intake to billing to risk management to the front line medical personnel. We also strongly recommend models that are patient-centered and trauma-informed.

We also believe we need to expand training for healthcare providers beyond the forensic exam. Most victims still never make it to the emergency room. Providers

need to be trained. Mental health providers, adolescent health, and OB/GYNs, as well as campus health centers, need training to understand and address the impacts of sexual abuse and trauma.

As you've already heard, sexual violence is also an often unrecognized element of abusive relationships. In fact, maybe as much as half of sexual assaults are actually perpetrated by partners. So that's about 22 million women who've experienced sexual violence by an intimate partner, nearly 3 million a year.

Importantly, we have evidence-based clinical interventions that improve the health outcomes and can reduce the violence. So we also need to be putting resources into those.

Specifically, what can we ask you to do in the next year? One, increase funding. The Health Resources and Services Administration has an advanced nursing education SANE program out of the Bureau of Healthcare Workforce. There was \$8 million that recently went out. That is an important first step, but we need to do more.

Provide dedicated funding to project catalysts out of the Office of Women's Health at HRSA. Pass legislation like the Megan Rondini Act that would increase requirements on hospitals to provide all survivors access to a SANE or information on how to get a rape kit if it is not at their hospital. As you've heard, though, we can't do the requirements if we don't have the workforce. We need to do both.

Pass the Violence Against Women Act, as we've heard by many of you, but include this new and improved health. As the GAO report pointed out, there is a VAWA health program, it has no dedicated funding, so we would ask for your help in supporting, creating a designated funding line.

We also have the Family Violence Prevention and Services Act that is also up for reauthorization. This is out of the Department of Health and Human Services, and so



that is also awaiting reauthorization similar to VAWA.

And the final thing I would ask. As you heard me say, Native American and Alaska -- Alaska Native victims experience violence at the highest rates. So we would ask included in VAWA the protections for Native women who are victims of sexual assault and child abuse.

Thank you.

[The prepared statement of Ms. Stewart follows:]

\*\*\*\*\* INSERT 1-4 \*\*\*\*\*

Mr. Harper. I want to thank each of you for your testimony. We look forward to asking you questions. I think this is such an important hearing, and we appreciate your attendance today. This is very helpful to us. We know we have some challenges, but this is not really a bipartisan topic; it's really a nonpartisan topic. This is something that has to be done to make sure that we improve greatly on what we're doing right now. So thank you.

This is now the opportunity for the members to have the chance to ask each of you questions. I'll begin by recognizing myself for 5 minutes for questions at this time.

You know, I certainly think that it's important that everyone understand why access to SANEs and SAFE kits is so important. According to the GAO report, when a survivor of sexual assault receives a sexual assault forensic exam, that exam can be done by a SANE that has specialized training in how to collect those kits or by a nurse or medical professional that does not have that training. But GAO, I believe, correctly noted that exams performed by SANEs have several advantages, including higher quality healthcare, and from a prosecution standpoint, a much higher quality evidence collection.

So, Ms. Jennings, I'd like to start with you, if I may. Explain to us briefly, what does SANE training entail and does that vary State by State?

Ms. Jennings. Sure. Thank you for the question. Our SANE training is two parts. So there is the adult component and then the pediatric component. The adult component consists of a 40-hour training, the didactic, so your actual classroom training. The pediatric is another 40-hour training in the classroom setting. And then there's a combined training of both adult and pediatrics, which is a 64-hour class that you can also take.

There are many options for both in-live classroom settings and there's also an option with IFN to attend an online training, which is very accessible to anyone in any

setting. Once you complete the classroom setting, there is a clinical component, and that's where we see the biggest struggle to actually find sites to do the clinical training. We have a really good access to the classroom component, but we have a very hard time finding sites for the clinical component.

Mr. Harper. You raised an interesting point because you have a separate training for pediatric.

Ms. Jennings. Yes.

Mr. Harper. But you may only have one staffer that's trained that may be there available on-call or at that time. Do you recommend that someone complete both components in the shorter combined class?

Ms. Jennings. In rural areas where there is smaller patient populations that they may not see large numbers of pediatric patients, that would probably be the best route to go so that you have both the adult and the pediatric component. Pediatric patients, from a forensic perspective and sexual assault perspective, are very different than adult patients. So it does take a bit more time to be very familiar and very competent with the pediatric patient population.

Mr. Harper. Are you able to tell us generally the cost for this training or certification?

Ms. Jennings. Sure. So if you take the training through the IFN, it's roughly \$500, based off of the online training. There are trainings that are State specific in addition to that that may cost an additional amount. I'm not familiar with that. I apologize.

Mr. Harper. Sure. You know, as we noted and I spoke of in my opening statement, the GAO found that limited availability of training is one of the major impediments that hospitals face in providing access to these services. So my

question -- follow-up question, Ms. Jennings, would be, where is training generally available? And how does availability -- and you said online, of course, but how does availability of training vary across different regions? Is there an urban versus rural component or is it a State-by-State issue? Can you elaborate a little bit?

Ms. Jennings. Sure. So the training I mentioned is through the IFN, the online component, which is both the adult, the pediatric component, the combined course. However, there are States that choose to do actual in-person trainings; those can be approved by the IFN. Some of those trainings are just done by providers within certain facilities.

Mr. Harper. Approximately, how many States offer in-person training? Do you have a general idea?

Ms. Jennings. I don't. I can tell you, I'm from Virginia, and we do offer several trainings throughout the State several times a year, but of course, that varies State to State.

Mr. Harper. Thank you very much. I appreciate that.

Another challenge that hospitals identified to the committee was the financial challenge of administering a SAFE program; however, several of the letter recipients were able to identify grant programs to fund SANE training.

So, Ms. Clowers, if I could ask you. The GAO report touched on various sources of funding for SANE training. Could you briefly describe how those funding sources and how hospitals can take advantage of those opportunities?

Ms. Clowers. Yes, sir. We identified three key grant programs at the time of our audit. All were administered by the Department of Justice, with the STOP grants being the largest, that's a formula-based grant, where all territories and States receive a set amount. At the time it was \$600,000, and then could get additional funding based

on population.

And what we found is that the amounts that locations receive varied greatly depending on the size of the population. And we also found that the entities that received those grants typically used the money for training. Forty-nine states reported -- grantees in 49 States reported using funding for training, which would include types of training that Ms. Jennings mentioned, whether it be classroom training, clinical training, and then importantly, the continuing education as well. In addition to the training, States reported using some funding for funding of positions. But less States reported using funds for those purposes. Only about -- grantees in about half of the States reported using funds for positions. And if they were using them for positions, it was typically for a program coordinator.

Mr. Harper. Thank you very much.

The chair will now recognize the ranking member, Ms. DeGette, for 5 minutes.

Ms. DeGette. Thank you very much.

Well, Ms. Clowers, following up on your testimony about the grant programs at the Department of Justice, those programs are of course included in the Violence Against Women Act reauthorization, which is set to expire December 21. So I want to ask you about -- and everybody here agrees, all of the witnesses, everybody in the audience, all of the Members of Congress sitting up here on the dais, we all agree this needs to be reauthorized. This is kind of one of the mysteries of Congress to me, why we have haven't done it.

So maybe you can tell me, Ms. Clowers, about the effectiveness of these three grant programs through DOJ, and why it would be important to reauthorize those in a timely fashion.

Ms. Clowers. Thank you. We heard from the officials from the States that we

interviewed and contacted for our review that these funds are very important. While some States have used -- grantees use State money or other types of sources of funding, the Federal dollars are a primary source of funding, and they go for the purposes that I just mentioned in terms of the training, the classroom training, the clinical training, the continued education, as well as funding needed positions.

Ms. DeGette. Ms. Stewart, are these -- some of the hospital associations told us that the hospitals did not have more robust sexual assault programs because of the cost of maintaining the programs. Are these programs costly to hospitals, and it is a prohibitive issue? What are the possible solutions to that barrier?

Ms. Stewart. So they certainly have a cost. Doing a good exam requires time. To be honest, when we talked to hospitals, there are so many things that they do that are so much more expensive.

Ms. DeGette. Right, that's what I would think.

Ms. Stewart. And, if anything -- you know, we are just having conversation, you know, that they lose far more on certain other things. And so we do not view this as prohibitive. Plus, as you pointed out, the Violence Against Women Act, can cover costs. Private insurance can cover many of the costs. We also share the view that victims themselves should not have to share the cost, but there are -- Victims of Crime Act funding also can cover some of the costs.

So we do believe this issue of training and ongoing certification is important and needs to get figured out. I think the other pieces are largely fairly easily fixable.

Ms. DeGette. And do you think there's some kind of bias in some of the hospitals against providing these services?

Ms. Jennings, you're nodding, maybe you want to tackle that.

Ms. Jennings. The reason I nod is I think hospitals historically see this as a

criminal justice issue as opposed to a health issue. And there is significant health consequences that are surrounding victims of sexual assault, and, therefore, we very much see it as a health determinant that we need to address as opposed to a separate criminal justice issue.

Ms. DeGette. Right. Well, I mean, it's health and it is criminal justice, but if you do it correctly, then it's patient centered, and that's what we really care about in the hospitals. And I've also got to say, you know, I'm from Denver, Colorado, where I have a really wonderful district attorney, Beth McCann, who is working quite closely with all of our hospitals, and then we have a wonderful hospital association, and we have -- and everybody understands how important it is to have these kits and how important it is to have trained people.

But the challenge, I would think, Ms. Clowers, is to expand that everywhere, not just in places where there's a certain number of people who think it's important, particularly in rural areas, I would think.

Ms. Clowers. Absolutely. In your State, I think we found that in the five rural counties in central Colorado, there was only one examiner program.

Ms. DeGette. Right.

Ms. Clowers. And so it's -- the need for the consistency across the State, making sure that victims, regardless of where they live, have access to timely care. I would say that it's also, though, capacity is needed in urban areas as well, even when there's an examiner program. What we found is there's not sufficient capacity to offer 24/7 care.

Most of the trained examiners are often wearing multiple hats, and so they're doing two jobs at once and more than two jobs. In addition, they're on call quite a bit. One study that we reviewed found, in Maryland, for example, trained examiners are on call 160 hours a month.

Ms. DeGette. Yeah. Ms. Jennings, do you have some thoughts about how we could expand the accessibility to people for SANEs, the nurse examiners?

Ms. Jennings. To follow up with Ms. Clowers, the piece of that, the program that I work for is a 24/7 operation with 14 full-time forensic nurses. So our model has shifted from a PRN on-call basis to truly being in-house 24/7, which has been very key in sustaining our nurses. We saw a 2-year turnover prior to that. And now we've had nurses that have been with us 4 and 5 years. So we've been able to retain those nurses, continue with their continuing education, and be able to have true competency within that group as opposed to constantly turning over staff.

So I think that a model shift from being an ER nurse that gets pulled out of staffing to take care of a sexual assault patient really needs to be the shift of the hospital focus.

Ms. DeGette. Thank you very much, Mr. Chairman. I yield back.

Mr. Harper. The ranking member yields back.

I have a quick question before I recognize the next member. And, Ms.

Frederick-Hawley --

Ms. Frederick Hawley. Yes.

Mr. Harper. -- I know you, looking at your response, the committee's letter, you had talked about the cost of the program, the SAVI program --

Ms. Frederick Hawley. Yes.

Mr. Harper. -- that had been slowly rising for the past few years. I think you indicated it was \$294,000 in 2017. Could you tell me how much of that cost was covered by grants and other outside funding opportunities?

Ms. Frederick Hawley. Sure. The vast majority of the grants that we use for the SAFE program cover the cost of the coordination of it. So it's our full-time staff that manage the SAFE scheduling, the recruitment, the training, the support of those SAFE



examiners, and the advocates. Some of it goes towards training, some of it goes towards equipment in the emergency department.

Up to this point this year, we have spent \$111,000 on the stipends that cover the on-call payment and the additional payment to the SAFE for when they come in on an actual case. We pay them both. We pay them just for being on call and also for coming in on a case.

Mr. Harper. Thank you very much. That's helpful.

The chair will now recognize the vice chairman of the subcommittee, Mr. Griffith, for 5 minutes.

RPTR TELL

EDTR HUMKE

[11:04 a.m.]

Mr. Griffith. What a personal privilege to begin with. I do want to thank you, Mr. Chairman. It has been great serving as your vice-chairman, and if we have another hearing that would be great, too, but you have been a great chairman and just all around good guy. I appreciate having worked with you these years. Thank you.

I do think that -- and I forget now who the testimony was from, but I do think it is important that we recognize it is both a health concern and a law enforcement concern, and so I have rearranged the way I'm asking my questions, but, Ms. Frederick Hawley, can you tell me a little bit about how your hospital and the Sexual Assault and Violence Intervention, SAVI, Program partnered with law enforcement and how that partnership benefits your patients?

Ms. Frederick Hawley. Absolutely. One of our funding sources, the New York State Division of Criminal Justice Services implemented that we have sexual assault task forces in all of the boroughs of New York City. So for instance, the work that we do in Manhattan once a month it is the special victims bureau of the Manhattan DA's office, it is the special victims division of NYPD for Manhattan, it is us, it is other SAFE Programs, it is other community partners that all come around a table and discuss different issues that arise. It has a benefit in two ways. We get to discuss cases and ongoing issues, but we also get to develop relationships such that if there is a concern about something that is going on with law enforcement around a particular case I can very easily pick up the phone and call special victims in Manhattan and say, I need help with this. And they're very responsive. So we have the good fortune where I work that it is sort of built into

our model that we work with law enforcement.

Mr. Griffith. And as a part of that have you found that -- I mean, obviously the victim when they first present themselves to the medical providers are distraught and not necessarily thinking clearly, has it been your experience that it is later that they realize how important it is or how they want to have some emotional closure or solace from the fact that the case is brought forward and that the evidence is preserved?

Ms. Frederick Hawley. The last time we did a statistical analysis it was about 67 percent of our sexual assault survivors report to NYPD during the time that they're in our emergency department and turn the kit over. The rest we hold them in security and then we continue to follow up with them until they make a decision. Many times they don't. Lots of times without certain supports in place they could fall through a crack, so if it is just them working with NYPD the likelihood of being able to carry forward under that kind of condition of trauma is -- it is very challenging, so the more we can be involved and support them the better the outcome.

Mr. Griffith. I appreciate that. Ms. Jennings, we have heard about the lack of appropriate transportation to the nearest sexual assault forensic examiner and that that is sometimes a barrier. I know you work in the Richmond area. My district is between 3 and 7 hours away from Richmond. One hospital that received our letter noted that they may provide a sexual assault patient with a taxi voucher. Obviously that can create problems on the criminal justice side because it can corrupt -- possibly corrupt the evidence. You got to go through a whole line of what happened in the taxicab, what kind of taxicab was it, you know, et cetera. And so that creates a real problem in the criminal justice system.

So that being said, for survivors that visit a hospital that doesn't have a SANE nurse on staff or does not provide that how do we best transport these victims to another

facility?

Ms. Jennings. And it is interesting that you actually asked that question. Recently in Virginia we do have about 13 healthy forensic nursing programs, and our program experienced a patient that presented to us after travelling to three different hospitals being told there's not a forensic nurse here, there's no way to do a SANE exam here, go somewhere else, and not provided with an actual facility.

In regards to the transportation what we primarily see is the patient either being transferred by ambulance so they'll go from one facility to our facility via an ambulance provider, so there's two people in the back potentially with the patient, but also law enforcement does transport some of these patients. Best case scenario is that the patient knows what hospital to go to, obviously.

Mr. Griffith. Right. Right. And obviously I represent a large and very rural district. Telemedicine, you touched on that in your written comments, and I'm a big fan, it may mean more witness time for certain SANE nurses, but what do you suggest on telemedicine if there's a rural hospital that doesn't have somebody, doesn't have the money to have somebody with the training?

Ms. Jennings. I do see benefits of telemedicine. I think that one piece of it there needs to be a very well trained forensic nurse on one end and then the nurse on the other end does need to have some basic training in forensic nursing. It may be a very brief course on evidence collection, but they need to have a little bit of knowledge prior to having that telemedicine piece set up.

Mr. Griffith. And my time is up, but I do want to find out, at some point I may ask a written question later about the clinical component of what we can do to make that better. Thank you. I yield back.

Mr. Harper. The gentleman yields back. The chair will now recognize Ms.

Clarke for 5 minutes for the purposes of questions.

Ms. Clarke. I thank you, Mr. Chairman, and I thank our ranking member. Good morning, everyone, and good morning to our panelists. The subject matter that we're discussing here today is so very important. I want to thank the chairman and the ranking member for today's hearing on such a very important, sensitive topic that's often gone woefully unaddressed with long lasting harmful impact on our Nation's survivors.

The subject of sexual violence in our country impacts millions of Americans, more specifically 23 million women and 1.7 million men that we know of. These staggering numbers do not even take into account the incidence of unreported assault survivors, who live in fear, in shame and in the shadows, and are often afraid to even come forward.

One of the major reasons individuals who have survived sexual assault are scared to report their attack is because the process is arduous and retraumatizes victims, causing them anxiety to face their assailant. That is why we are gathered in this room today to understand how the Congress can provide support to those who need it the most and to obtain justice.

There is both a shortage of supply of sexual assault forensic examination kits, SAFE as we have been talking about, as well as sexual assault nurse home examiners, SANE. As one of the wealthiest most advanced civil societies in the world there should be no barriers to care for the most vulnerable in society, especially at the critical stage of collecting forensic evidence to provide justice to those brave women and men.

To add insult to injury victims of sexual assault should not be required to pay for the forensic exam or emergency room visit. In the Ninth Congressional District of New York that I proudly represent just as recent as November 30 of 2018 the New York Attorney General Barbara Underwood announced that at least 200 sexual assault survivors were illegally sent bills from seven New York City hospitals requiring payments

ranging from \$46 to \$3,000. Thankfully the New York State Attorney General committed to righting this wrong and protecting survivors, as well as their rights.

And I'm so proud to hear from Ms. Frederick Hawley today of Mount Sinai who has a hospital site in my district here today, and I want to open with my questions to Ms. Hawley.

I would like to take a few minutes to discuss the details of Mount Sinai's program and to see what best practices you would offer to other hospitals looking to develop and expand a sexual assault program. Ms. Frederick Hawley, could you tell us a bit more about how your program got started?

Ms. Frederick Hawley. Well, originally in 1984 we had a sexual assault survivor come into the emergency department, and there were a couple of medical students working that evening. And after this patient was discharged they looked at each other and said, We have got to be able to do better than that. And so they started to think through what a rape crisis program would like. They found a donor for the hospital. They sat at her kitchen table and developed SAVI. So it was a very grassroots based out of the need to do more for survivors sort of effort, and we carry it forward from there.

The moment we hear of an emerging need we try to address it the best way possible, and I'm fortunate that I get to do this work at the Mount Sinai Hospital because they have been incredibly supportive and have always recognized that this is an important aspect of the kind of medical care that we want to provide.

Ms. Clarke. Absolutely. And would you tell us a bit more about the services that SAVI provides through this program and the impact it's had on victims?

Ms. Frederick Hawley. Absolutely. So since 1984 we are not just a rape crisis program anymore. We currently send advocates of -- our certified volunteer advocates that we train on a 40-hour basis, it is a DOH-certified training curriculum that we have

developed. We send them to eight hospitals, including some city hospitals, private hospitals and throughout the Mount Sinai system to service survivors of any kind of sexual violence and intimate partner violence.

We have a court program and an ongoing therapy program for sex trafficking survivors, both domestic and international. We have a three full-time staffed education and training department where we're working on primary prevention. We have a component called Talkanote, which is specifically for Orthodox Jewish survivors of any kind of sexual violence or intimate partner violence.

We have therapists, trauma therapists in six different locations in Manhattan and Queens who provide mostly short-term brief trauma therapy, but it can go on a longer term depending on what the person needs, and also we do all of this extensive emergency department care with our SAFEs and our advocates in terms of providing anything they need in that moment from a medical and psychological standpoint to any ongoing need that is going to come up that we want to be able to help empower them to either find service for or that we can provide service for. All of our services are free, and we provide them in 10 different languages currently.

Ms. Clarke. Outstanding. I thank you for all of your service. And I yield back, Mr. Chairman.

Mr. Harper. The gentleman yields back. The chair will now recognize the chairman of the full committee, Mr. Walden, for 5 minutes.

The Chairman. Thank you, Mr. Chairman. Again, I want to thank our witnesses for being here today and for the testimony you submitted for the record.

Ms. Jennings, you noted in your testimony that telemedicine can be used to improve care for patients in rural and low volume communities, and I certainly know that my -- just point of reference my district is bigger than almost any State east of the

Mississippi, so it is enormous territory, very rural.

Would you tell us a little more about telemedicine and how it can be used to expand access to these types of services and what are some of the challenges you see facing telemedicine to treat survivors of sexual assault?

Ms. Jennings. Absolutely. Thank you. Telemedicine is for sure an answer to some of the more rural communities that don't have access to forensic nursing care. They could have to travel, as we mentioned before, as many as 3 to 7 hours to have a trained provider. Telemedicine would allow a nurse or another provider in the ED setting to care for that patient via telemedicine with another trained provider on the opposite end, walking them through the evidence collection process, walking them through injury identification, walking them through any prophylactic medications that the patient may need at time of discharge and then go through discharge planning, whether it be follow-up with a rape crisis advocate or whomever. The person on the other end would be able to elaborate on those services and care via telemedicine.

The Chairman. Are there any statutory barriers, regulatory barriers either at the State or Federal levels you're aware of that would -- that hamper this ability?

Ms. Jennings. I'm not aware of specifics, but I do know that there are some challenges specific to that, and it will vary State-by-State.

The Chairman. Any other panelists want to weigh in on that from your experiences on telemedicine?

Because it is really hard again in a district such as mine just to recruit healthcare providers period, nurses, et cetera, and then when you get into something specific and the more we regulate the training the less likely it is they can find somebody like that to be there.

Ms. Clowers. We through our work in talking to officials from different States



this was one of the best practices or promising practices we heard about. Using web-based training, for example, to get both the sort of classroom as well as some clinical training opportunities, but then as Ms. Jennings was describing too providing that clinical guidance real time.

We heard about examples in Colorado where a program coordinator in an urban area will be on call to help those in rural communities that don't have an examiner program. And then also we heard about the program, the SANE program in Massachusetts, which provides clinical guidance real time to nurses across the State.

The Chairman. Very good. In addition to the challenges noted in the GAO report on volume versus competency issues one issue we have heard expressed by hospitals is that they're able to have SANEs on staff because they have so few -- or they're not able because they have so few patients seeking kits each year that their nurses are not able to maintain competency in performing the SAFE kits. So I wonder, I understand at Mount Sinai you have had 23 SANEs on staff. How many kits do you perform on an average basis annually?

Ms. Frederick Hawley. Year to date as of this morning we had 55 cases of sexual assault at the Mount Sinai Hospital.

The Chairman. Wow.

Ms. Frederick Hawley. And only one of them did not have a SAFE examiner, person got sick at the last minute.

The Chairman. Ah. So 23 nurses and about 55 cases this year. Is it fair to say you may have some nurses that do not perform any kits at all then?

Ms. Frederick Hawley. Absolutely. And I should clarify that there are now 24, and they're not all nurses on our particular program.

The Chairman. Okay.

Ms. Frederick Hawley. So I have physicians assistants, RNs, APRNs and residents and --

The Chairman. So other healthcare providers.

Ms. Frederick Hawley. Other healthcare providers. It is possible there are some times when we allow our SAFE examiners who are on the roster to take a leave, they need kind of a break from that work.

The Chairman. I'm sure.

Ms. Frederick Hawley. And so we have an intensive number of people who take many more on-call shifts. So there are periods of time sometimes when one of the SAFEs hasn't done an exam in quite a while. We do have things in place for them where our assistant medical director for our SAFE Program is available to talk them through if they're back to do a case for the first time after a hiatus.

The Chairman. I was going to ask about that. How do you maintain that competency in training then in the interim?

Ms. Frederick Hawley. There's also always a SAVI staff person on call to the SAFE examiner in case any questions come up or if they just want to kind of touch base and know that they're not out there alone. Often times, too, our SAFE examiners work in the emergency department, so you will often find that while the person who is on call is coming in to respond to that patient there is another SAFE-trained person there that they can bounce things off of if they need to. So there are a lot of layers of support for our particular examiners.

The Chairman. Excellent. Thank you. And thanks again for your testimony, all of you. I appreciate that. Mr. Chairman, I yield back.

Mr. Harper. The chairman yields back. The chair will now recognize the gentlewoman from Florida, Ms. Castor, for 5 minutes.

Ms. Castor. Well, thank you, Mr. Chairman, and I have to say, Mr. Chairman, it has been a pleasure serving with you and working with you on legislation. Thank you for your service on the committee and to the country.

Mr. Harper. And if the gentlewoman will yield, it was certainly a pleasure for me to be able to serve with you at the very beginning on our Ethics Committee and the great work that you did there.

Ms. Castor. Especially the caregivers bill.

Mr. Harper. That's right. Particularly that. That was this year. Thank you.

Ms. Castor. And thank you to our witnesses for being here and helping raise awareness to this critical issue for sexual assault survivors. Back home in Florida in the Tampa Bay area we're very fortunate, we have an outstanding crisis center of Tampa Bay that has been a leader for decades, and I guess I was naive in assuming that a lot of this the services the integrated services with hospitals and providers and on-call experts and forensic nurses and specialists that was just the standard across the country, but it is clear that it is not, and we have got to do more to make sure that professional forensic specialists are available to everyone in America no matter where they live.

The other issue that has been an issue in the State of Florida and other areas is actual processing of the sexual assault kits. And for anyone that's interested in this, the State of Florida, the Florida Department of Law Enforcement posted on their website a progress report because it came to light a few years ago they had over 8,500 kits that had not been processed. And to their credit, they appropriated some money, and right now they have completed over 7,000 of those kits but still have a thousand waiting.

Ms. Clowers how are we doing on processing kits across the country?

Ms. Clowers. We have an ongoing work looking at the issues of processing kits and the backlog of kits that are out there and I'm happy to arrange a briefing for you or

your staff on that work as it comes to fruition.

Ms. Castor. Good. Thank you very much. The other big issue as Ranking Member DeGette has mentioned is the impending expiration of the Violence Against Women Act. It is December 21 that it would lapse, and this Congress has got to get it together to pass this landmark law and reauthorize it. It contains several provisions that address health issues associated with sexual violence, including the grant programs that we previously discussed that help fund and train sexual assault forensic examiners and address the public health response to domestic abuse.

Ms. Stewart, your organization has had a long history in advocating on behalf of Violence Against Women Act. Again, why is it so important that the act be reauthorized as soon as possible?

Ms. Stewart. So VAWA serves as a cornerstone of the Nation's response to domestic and sexual violence as you have pointed out. It includes both provisions that set standards for the law but it also provides grant programs to do exactly the things you have heard us discuss today. We also would advocate -- I know we're talking primarily about the response after a sexual assault has happened and the effort to try to prosecute and hold offenders accountable. VAWA also has numerous programs that fund what we call the coordinated community response, which is really the ideal response to these forms of violence. We can't just wait until people are raped, and we need -- we appreciate this hearing, we appreciate the focus on giving people the best care and holding offenders accountable, but that cannot be our Nation's response to sexual assault.

We need to stop it through prevention and early intervention programs, through programs that bring law enforcement together with health, together with advocates, which we haven't really touched on yet, but so much of the success of these programs

really is these partnership issues, how do we bring healthcare and law enforcement together? VAWA does that.

Ms. Castor. I strongly agree, and I also -- as you mentioned before I also believe it is time to improve the VAWA health title as you mentioned Mrs. Dingell and Mr. Costello along with Ms. Clarke, who was here and I we have filed legislation and that is to do more on the behavioral health side, but clearly we have got to help, we have got to put more dollars into training sexual assault examiners.

And you mentioned -- you all mentioned a bill by Senator Murray. Is that -- that I believe has been replicated here by in legislation by Rep Jayapal. Are there other bills that you would highlight to us today that we need to work on as soon as possible?

Any of the witnesses.

Ms. Stewart. You know, we still obviously look to VAWA and the VAWA health provisions as you said, and I think what's important that you pointed out was the relationship between suicide prevention -- you know, we're looking at a lot of the report language in some cases, and we look at we have a huge epidemic in this country primarily of male suicides. What we see from some of the data is really unaddressed sexual violence in childhood in some of those cases.

Our opioid addiction, which I know, you know, so many frankly, members on this committee have been focused on, how do we address violence as a driver as that and as part of our treatment. So some of those laws, some have passed, some are still sort of close to the final stretches, and integrating violence prevention language into those other programs is critical.

We have also obviously discussed the Megan Rondini Act that Judge Poe has been advocating, and we think that that's an important legislative goal that we would encourage the committee to pursue.

Ms. Castor. Thank you very much.

Mr. Griffith. [Presiding.] I thank the gentlelady. I now recognize the gentleman from Texas, Dr. Burgess, for 5 minutes.

Mr. Burgess. Thank you, Mr. Chairman. I was going to recognize your long service as chairman and how much I regret the fact that you're leaving, but you're not the one who is leaving, so I'll save that.

Mr. Harper. I am here.

Mr. Burgess. Oh, you are here. I do regret that you're leaving, Mr. Harper.

Let me just ask, and this has been a fascinating discussion this morning, but just to orient me, Ms. Frederick Hawley, you're in New York at Mount Sinai Hospital. Is that correct?

Ms. Frederick Hawley. Yes.

Mr. Burgess. Ms. Stewart, San Francisco General Hospital?

Ms. Stewart. Our organization is based in San Francisco, I'm here in D.C.

Mr. Burgess. You're here in D.C., okay. And Ms. Jennings, your hospital?

Ms. Jennings. Bon Secours in Richmond, Virginia.

Mr. Burgess. Very good. I was a medical student 10 years before your medical students that you discussed in 1984. I did my residency training at Parkland Hospital in Dallas, and even back in the seventies and early eighties Parkland had I thought at the time a very forward leaning program in this regard. And I'll tell you one of the things that always impressed me about it as an OB/GYN resident. We were not tasked with covering a case when a patient came in complaining of sexual assault. That immediately went to a faculty member, who was onsite in hospital 24 hours day and available. And part of me at the time always resented having a faculty member in hospital, but in these cases it was clear that -- and I think Norman Gant and Jack Pritchard, at the time,

recognized that in order to have the availability of someone to precisely collect the information and then provide expert testimony in the courtroom was critical in the satisfactory resolution of these cases.

And I don't have numbers, but I remember getting the impression that some defendants would plead before getting to the courtroom because the case would be so strong against them. And again, you had a faculty member from Southwestern Medical School as the expert witness, so that was always pretty powerful to take that into court.

And then, of course, as a resident I ended up staying in the area, but I certainly recognize that somebody completes their residency after 4 years they may be gone miles and miles and miles away and not available for a court case, and then a case could be lost because of lack of the availability of the person who is to present the testimony. So I became convinced early even before I began my private practice that this was the correct approach.

Now, I did not practice in Dallas County. I was a county removed, and I remembered trying to set up a similar program in our hospital, community hospital, and there was significant barriers to doing so. At the time there were not the advanced nurse practitioners who were -- who you talk about this morning as available to do this.

Of course in 1988 this Congress, not this Congress, but Congress passed a law called EMTALA. Can any of you speak to me as to whether or not your screening exams, for somebody who comes in complaining of sexual assault, does that satisfy the EMTALA requirements as set forth by Congress in 1988?

And anyone who feels that they can answer that.

Ms. Jennings. Thank you. So our facilities that we do receive transfers from we do ask that they follow the EMTALA process. There are some facilities that, again, don't see this as a healthcare issue, therefore, they don't follow the appropriate EMTALA

proceedings.

So we ask for a doc-to-doc transfer, and we do ask for a nurse-to-nurse report, but many times that's not happening, they're just telling the patient we don't have that here and you need to go elsewhere, so it is not occurring.

Mr. Burgess. Yes, Ms. Frederick Hawley, were you going to say something?

Ms. Frederick Hawley. We don't have an EMTALA issue in New York State because of sexual assault. It is actually required that if a patient presents in an emergency department in New York State saying they have been raped and they would like to have a kit done there every hospital has to be able to conduct a kit. It is not necessarily done by someone who is SAFE trained, but someone's got to figure out what to do and how to do it.

Fortunately for the most part in New York City there are ways that people can be trained or they have exposure to the idea of providing a sexual assault forensic exam. A lot of it is anxiety on the part of someone. They want to do the right thing, they want to do it well --

Mr. Burgess. Sure.

Ms. Frederick Hawley. -- and are concerned that they won't be able to, and their instinct may be to we need to send this patient to some place else, but if the patient wants to stay in that particular ED and that's where they want their exam done then that hospital needs to figure out how to do it, and every hospital has to have kits on hand to perform.

Mr. Burgess. And will you generally because if a patient is a regular patient of a practice in your communities will you call the doctor or practitioner who is the regular provider of care for that patient?

Ms. Frederick Hawley. Call their like their OB/GYN, for instance, into the



emergency department to do --

Mr. Burgess. Even to let them know their patient is being seen with that complaint?

Ms. Frederick Hawley. Everything that we do is based on what that survivor, that patient wants and allows us to do at that moment.

Mr. Burgess. So if they request you call their doctor --

Ms. Frederick Hawley. If they request it we would call anyone that they wanted us to, yes.

Mr. Burgess. And I know I have gone over time, but how do you address the freestanding emergency rooms that we see so frequently cropping up in our communities, are these facilities equipped to handle these types of exams that you all provide?

Ms. Frederick Hawley. I think it varies. So, for instance, Mount Sinai has several urgent care centers that we will send our SAFEs to if someone presents and wants to have their evidence collection done there. But I can't speak for all of those kinds of --

Ms. Jennings. I don't see freestanding EDs as being a barrier to care, to service. We also in our facility we have two freestanding emergency departments, and we provide the same care and have not seen it as barrier, but it differs, of course, from State-to-State.

Mr. Burgess. And I recognize that, and, of course, I'm in full favor of states being in charge of their sovereignty, but CMS is a national -- I mean, Medicare is a national program so CMS oversees the EMTALA, so it seems like there's -- I'll be the last person to say I want EMTALA to be bigger, or stronger, or harder, but at the same time they do exist, and CMS is the oversight of that program not State-by-State. Thanks. Mr. Chairman. I'll yield back.

Mr. Harper. [Presiding.] The gentleman yields back. The chair now recognizes the gentleman from Michigan, Mr. Walberg, for 5 minutes.

Mr. Walberg. Thank you, Mr. Chairman. And I, too, want to say thank you for your service, your leadership, your friendship. We're going to miss you, and every time I go back to the base of my district in Jackson, Michigan I'll think of you in Jackson, Mississippi.

Thanks to the panel for being here as well on this important topic, and it is a shame that it continues to be such a massive concern, but it is a concern, and we have to address it so thank you for your efforts and probably your sacrifice that you go through in dealing with this topic and these issues.

GAO's report noted that only limited nationwide data exists on the availability of SANEs and that only one of the six States examined had a system in place to formally track the number and location of the SANEs. Some States, including Massachusetts, Colorado and Texas I'm told make public a list of SAFE ready facilities. Other States do not appear to make these sorts of resources publicly available.

Let me ask each of you if you care to answer would this kind of national database or at least statewide databases be helpful to survivors?

Ms. Clowers. I would think a national database or some type of centralized information about the availability would be helpful to patients. It would eliminate some of the challenges that were discussed earlier about arriving at a hospital maybe after a long distance, especially if you're in a rural area you have traveled an hour, 2 hours to get to a hospital after a very traumatic experience only to be told we can't serve you here, you need to go somewhere else and being told to get in a taxi or to drive yourself.

You know, what we heard is once the patient leaves the hospital the chances of them returning to the hospital for care diminishes.

Mr. Walberg. Okay.

Ms. Jennings. I would also agree. Many hospitals are already scored based on services that they provide, and I think this should be something that's included and something that is very accessible to patients. We're in a digital age, and if someone can flip open their phone and say where is the closest facility to receive this type of care I think the care would be much more accessible, and that could then also be translated to law enforcement and to many other of our community partners so that they immediately know if they are referred a patient where they need to send them to very quickly.

Mr. Walberg. Jumping on that, what other digital resources could be offered online, for instance, to assisting that type of information getting out?

Ms. Jennings. Sure. Something that we have seen is within our college student patient population they have apps from their school that will say if this happens to you this is what you need to do, whether it talks about evidence preservation or it talks about what type of medical services they could receive, whether it be a forensic nurse or the student health center. So some of those types of apps that are very accessible -- I know many of the rape crisis centers also utilize some of those similar resources.

Mr. Walberg. How widely is that used or known, those apps?

Ms. Frederick Hawley. In my experience running into college students who know is kind of like running into a polar bear on the street of Manhattan. It is kind of rare at this point, but I think that it is potentially growing, but there are always glitches to figure out with that, and then how to get the education and the availability of it to those students and to the larger population when you have a sort of technology divide. Not everybody has the same access to technology, which is problematic when you're talking about a really important basic service that you want everyone to have.

Mr. Walberg. We're so app based today --

Ms. Frederick Hawley. I know.

Mr. Walberg. It seems like that would be just an automatic, but something to think about. Thank you.

Ms. Frederick Hawley, does Mount Sinai track information relative to data available for SANE programs? I guess what I would say is one of the questions the committee asked in our letter to hospitals was whether each hospital tracked any data as it relates to sexual assault such as number of sexual assault survivors treated each year and how many kits are requested and completed.

Does Mount Sinai track this information as it relates to patients?

Ms. Frederick Hawley. Yes, we track an incredible amount of information on our sexual assault patients, the relationship they had to the assailant, how acute was the assault before they came into the emergency department, whether they were eligible for emergency contraception and other kinds of prophylaxis and beyond eligibility whether they decided to avail themselves of it, including HIV prophylaxis.

We track, you know, who the SAFE examiner was that saw them, who was the advocate, other kinds of services they needed at the moment and then all of our follow-up care, as well.

Mr. Walberg. I'm certain that that shapes your SAVI Program then to a great degree.

Ms. Frederick Hawley. Absolutely. Yes. And we have to report that at this point to a variety of our funders all confidentially; we don't include any kind of identifying information, but that's the kind of data that the New York State Department of Health and New York State Division of Criminal Justice Services and to a certain extent the New York State Office of Victims Services because of our funding streams requires us to provide to them.

Mr. Walberg. Thank you. I yield back.

Mr. Harper. The gentleman yields back. The chair will now recognize the gentleman from Georgia, Mr. Carter, for 5 minutes.

Mr. Carter. Thank you, Mr. Chairman. I certainly would be remiss, Mr. Chairman, if I didn't offer my thanks to you as well for your leadership in this committee and for your service in Congress. Thank you.

Ladies, thank you for being here today. This is a very important subject and it is very important to me personally because we have had this issue in the State of Georgia. We have had a problem here.

And I want to start off by asking about the shortage of kits. Is that a problem, just the shortage being able to get the kits to where you can perform the -- and I would offer this to anyone who wants to answer to where you can perform the examination?

Ms. Frederick Hawley. It is sort of our responsibility as a program. We keep track of how many kits we have on hand both drug facilitated sexual assault kits and the sort of more general forensic evidence collection kit. And as we start to get low we have to reach out to the Division of Criminal Justice Services and say, hey, send us some more --

Mr. Carter. So it is it their responsibility, the criminal services to provide the kits, is it the State's responsibility, is it health systems responsibility? Whose responsibility?

Ms. Frederick Hawley. The Division of Criminal Justice Services in the State of New York is the one responsible for pulling the kit together and -- every few years we review what's in the kit, and if there are changes that need to be made to the samples or the envelopes or the content or anything like that it is up to them to build what kit is used in a standardized way across the State, and then it is up to the facilities to identify --

Mr. Carter. Make sure that they have enough. Is anybody different from that?

Ms. Jennings. We receive our kits in Virginia from the Department of Forensic Science.

Mr. Carter. Okay.

Ms. Jennings. So very similar, once we recognize that we are running low on our kits we call and have a courier bring us to do, but it is our responsibility to actually have those kits in our facility.

Mr. Carter. Okay. One of the things that I wanted to touch on, and I recognize that this is not necessarily why you were here or your responsibility but is the processing of the kits. We had a big problem in the State of Georgia, I think it was also alluded to by one of my colleagues in their State, but we had a big backlog, and that was causing all kind of problems. This whole system doesn't work until we complete it.

I mean, we need SANE nurses. We need the whole process to work, including processing the kits. We had examples in the State of Georgia where we had, you know, a serial rapist, if we had simply processed the kit from before we could have identified him. Is that a problem anywhere else that you're aware of?

And, by the way, we have caught up in the State of Georgia, so I'm very proud to say that and to report that.

Ms. Stewart. So thank you so much, Congressman, and congratulations to the State of Georgia, as well. I was actually going to commend Congressman Walden because Oregon is also one of those States that made a concerted effort and has reduced their backlog. It varies tremendously by State, but you identify a critical issue, which is why in some cases many -- I shouldn't say many.

Some victims do not go and why to get the kit is if the kit isn't going to be processed anyway or why law enforcement themselves sometimes and why we have burnout. And we hear from some of the providers that if the kit is not even going to be

tested it is a very difficult, difficult thing for a victim to go through a rape kit. You don't do it lightly or easily --

Mr. Carter. Okay. Let me ask you this, and please bear with me on this. I'm not suggesting that the program itself is not needed or valid, but I'm a pharmacist and right now I'm cramming in 30 hours of continuing ed by the end of the year so that I can keep my license, okay, but are there any continuing ed programs out there that perhaps even if you don't get the certification it would certainly help to have some kind of knowledge for the nurse to be able to have a continuing ed program or something?

Ms. Jennings. There are many opportunities for continuing education specific to the forensic component sexual assault many other types of victims of violence, so yes, that is definitely an opportunity.

Mr. Carter. And I would ask you this to take it just a little bit further, what are we doing to educate other healthcare professionals besides nurses and law enforcement, making sure that, you know, because again as I stated earlier this process only works if it is completed. If we have a law enforcement officer who is trying to determine whether there was a rape involved here and whether this person needs this help, are there programs like that available?

Ms. Clowers. There are. In talking to officials from the States that we interviewed this gets back to the multidisciplinary teams. Bringing law enforcement and healthcare providers together to make sure they understand each others' roles, to make sure they understand the availability of the examinations and the process that they'll go through. So, again, that was an important element that we saw in the States.

And to your question about continuing education while there are opportunities available this goes to one of the challenges we found was weak stakeholder support for that training. Because some hospitals may receive only a low volume of patients not a

great number of patients that need this care, hospitals may be reluctant to send their nurses or other practitioners to the training. And, in fact, some cases won't pay for the training so the providers if they go to the training they're taking annual leave, they're paying for all the costs associated with the training.

Mr. Carter. Right, right, right. The last thing I would add, and I know we have talked about it, but I represent the coast of Georgia in Southern Georgia, a very rural area telemedicine, telehealth we need to look at that. That's our only option in the rural areas because we just, you know, we have enough trouble attracting physicians and healthcare professionals, much less specialists like this, so I hope that you'll continue to work on that because it is vital to rural areas in our country.

Thank you, Mr. Chairman. I yield back.

Mr. Harper. The gentleman yields back. The chair will now recognize Mrs. Brooks for 5 minutes for the purposes of questions.

Mrs. Brooks. Thank you, Mr. Chairman, and I want to thank you for your leadership of the committee, but I also want to thank you and the ranking member for bringing this topic to our last hearing of the year. And I want to thank all of the panelists for this incredibly important work.

Many, many years ago in the late nineties when I was deputy mayor in Indianapolis and focused on crime issues I had the opportunity to have a SANE nurse or people demonstrate for me what the SANE project was in the late nineties and what the concept was and how it worked and how incredibly important it is, but I have to admit until there was that big article about the lack of testing of rape kits and so forth there hasn't been tremendous amount of attention on the lack of SANE and SAFE Programs and on all of the challenges, and so I want to thank you for the recommendations you have been giving to us.



I also want you to know that we have been and are going to continue to push for the Violence Against Women Act to get included in whatever package comes at the end of this year. Myself and others have written letters to the leadership asking them and imploring them to please ensure that the Violence Against Women Act is included and that the funding continues. And so we're going to continue to push on that.

But I want to just ask a couple of questions about the retention rates and the challenges because when people finally agree, and you might have to convince people to enter into this work because it is so incredibly difficult, but I know that there has been and Ms. Jennings you mentioned some significant retention issues but your hospital system is doing a lot.

Ms. Frederick Hawley, is your system, what are you doing for the retention of the people who finally agree to go through because GAO found that in one situation 540 SANEs were trained over a 2-year period in one State, fewer than 8 percent stayed because of the difficulty of the work.

So what are you doing? Is it compensation, what are you doing to keep the retention rates high first at Mount Sinai and then if you would like to go on further?

Ms. Frederick Hawley. We see it as a multi pronged effort to keep people on the roster, recognizing what my colleagues up here have said about it being very difficult and taxing psychologically and physically to do the SAFE exams. We try to provide as much support as possible as close to the time of the case as possible.

So every SAFE is required to call our SAFE coordinator and debrief everything about that case after they have gone in on it. And it is not just were there, you know, how did the camera work, were there any problems with anything like that, how was law enforcement, all of those other pieces.

But how are you, how did this go for you. We keep track. It is why

coordination is so important in my opinion because we can keep track of who is taking an absurd number of on-call shifts and say maybe we can ratchet that back a little bit and to take care of them as a person.

We also provide in-house ongoing continuation education. We do a monthly support meeting. We bring in outside speakers, but we also will sit them down and, you know, retrain them or reorient them to the colposcope equipment, so we try to do a lot of things that are on an ongoing basis to --

Mrs. Brooks. Are they compensated in any way for their additional training or do you have any incentives to at Mount Sinai or at your system?

Ms. Frederick Hawley. We pay the SAFE examiner for being just on call.

Mrs. Brooks. Okay.

Ms. Frederick Hawley. And then we also pay them an additional amount when they are called in to do an actual case. So their time is always important to us and considered valuable, which I think makes a difference. We pay for their certification training so they don't have to worry about that. And we also will provide resources to be able to cover their ongoing continuing education.

Mrs. Brooks. And Ms. Jennings --

Ms. Frederick Hawley. I'm sorry, if they're called in to testify we will also work out compensation for the time for preparation and things like that.

Mrs. Brooks. Good. And, Ms. Jennings, anything that your organization is promoting relative to compensation of --

Ms. Jennings. Absolutely. Very similar to Ms. Frederick we compensated for any training. We provide compensation for their SANE-A and their SANE-P certification from the IAFN, so that's the certification exam once they have completed their clinical and didactic training.

We also compensate for any time that they're coming into the hospital for meetings. We keep them very engaged within the hospital system, but we also keep them very engaged with our community partners. So we have our nurses assigned to our sexual assault response team. Our program serves 26 different counties and jurisdictions within the Commonwealth of Virginia. So each of our nurses has a jurisdiction that they partner with, and so those relationships are extremely important.

One other thing that we have done that's been huge for our retention rates we have transitioned from more 12-hour shifts to 8-hour shifts. We saw that nurses truly were having high burnout rates when they were there for 12 hours. A shift typically didn't end at the 12-hour mark it was going into the 13th and 14th hour, so we have transitioned back to 8-hour shifts.

Mrs. Brooks. Thank you. I may submit a couple of written questions for our witnesses because I had more, but thank you for your work. I yield back.

Mr. Harper. The gentlewoman yields back. The chair will now recognize the gentleman from Pennsylvania, Mr. Costello, for 5 minutes.

Mr. Costello. Thank you. First, I just want to recognize the leadership and service of the subcommittee chairman here as he winds down. It has been a pleasure to work with you, and I want to thank you for your service as well as those testifying here today.

My question is for Ms. Clowers and for Ms. Jennings. I'm going to try and speed through these. In your testimony, Ms. Jennings, you mentioned that one of IAFN's goals would be to establish a standardized national sexual assault evidence collection kit. Could you tell us what makes up the actual kit and some of the discrepancies you have seen in different localities? Can this lead to issue with prosecution if a kit is collected in one State but the crime is prosecuted in another State?

Ms. Jennings. Thank you for your question. One of the issues that we see is that there are many variations in the kits themselves. Some are received from the Department of Forensic Science, some are received from actual online ordering options, so the kits can vary by State. I would venture to say, yes, that could create issues with them being different, but that also creates a huge barrier in training. If we had one standardized kit it would be much easier to educate --

Mr. Costello. To train. To train, good point.

Ms. Jennings. To train.

Mr. Costello. What's in the actual kit?

Ms. Jennings. In the actual kit, many different swabs from areas, so when we're obtaining a history from a patient we're asking them what actually occurred so it guides our evidence collection, whether it be an oral assault or a vaginal assault we know where to collect our swabs from very much like a Q-tip and a slide you would use in biology class. We do take hair samples, and we take blood samples also.

Mr. Costello. What are the most notable discrepancies, most common discrepancies?

Ms. Jennings. For example, the kit in Virginia is about a shoe box size, but a kit that may be in another State is the size of an envelope. So the actual number of the swabs in the kit may be less or there may be not blood samples in one but there would be blood samples in another.

Mr. Costello. How about reimbursement or processing of kits, difference?

Ms. Jennings. I can't speak for every State. In Virginia we go through our Virginia Victims Fund for our compensation for our sexual assault exams.

Mr. Costello. Okay. If there's nothing to add I'll go to the next question. Anyone else want to add to that?

Is there a need to create a national standard of care for the treatment of sexual assault survivors, whether that means a standardized training program as you mentioned or standardized procedures for hospitals that are not equipped to collect SAFE kits?

Ms. Jennings. Yes. We think that that is very important. That would also create the consistency amongst trained providers so that everyone is practicing the same.

Mr. Costello. Anyone else? You can't really add to a yes, can you? Okay.

In addition to a lack of standardization of the kits themselves one issue we heard expressed by a hospital association is that, quote, "lack of reciprocity to allow nurses who are not part of an independent team to go from one hospital to another," end quote.

For any of our witnesses, is this a problem you have seen in your experience and can you identify a solution to this issue?

It is a problem would you agree? And so the challenge becomes what's the solution.

Ms. Jennings. It is a problem. I don't have a necessary solution at the moment in our particular area. It would be difficult to go from I work for Bon Secours, but if I went to another healthcare system that I was not employed by that could create some issues.

Mr. Costello. Could I ask each of you to submit in writing just think about that a little bit and share with the committee some thoughts, just kind of brainstorm it through.

Ms. Frederick, you were shaking your head, which presumably means you agree and you probably struggle with that issue, as well. Anything to add from what Ms. Jennings said?

She said it expertly. Okay.

Let me see if I have anything else that I would like to ask. Okay. One of our letter recipients noted that they have used an online training program to train their

nurses. How can we overcome the issue of making clinical training available even if we can make the classroom training available online? How can we overcome the issue of making clinical training available?

Ms. Frederick Hawley. In my opinion to be honest I don't think you should ever overcome the clinical training part. I believe that maybe moving away from didactic in some ways and doing online modules, and we do a combination of those things, but the hands-on work with a patient that you are going to be seeing in a much more traumatized state the first time you're doing a real exam it is invaluable to use a gynecology teaching associate in a clinical setting to actually go through what kind of sensitive approaches you're going to need, what your anxieties are that come up in that sort of --

Mr. Costello. That's an excellent point. In other words, do not ever supplant entirely or only up to a certain percentage the amount of -- and related to that I know I'm out of time, can you tell us more about the practice transporting nurses from rural low volume areas having them spend more time in more urban high volume settings in order to gain expertise and experience, do you recommend that and how does that take shape?

Ms. Clowers. It is certainly a strategy for maintaining clinical expertise, but it would require the support of the hospitals. And again, that's one of the challenges we found is that there is weak stakeholder support for those types of initiatives.

Mr. Costello. Very good. I know that what we have heard is some groups have advocated that as being a thing, and you have identified what the chief impediment of having that be a solution.

Ms. Clowers. Yes.

Mr. Costello. Thank you very much. I yield back.

Mr. Harper. The gentleman yields back. I want to thank each of the witnesses for being here for the valuable insight and suggestions that you have given to us.

One thing that we can say is that no victim of sexual assault should ever be turned away from any hospital, bottom line.

Certainly I thank the members for their input today as well, and as I conclude what in theory should be my last hearing to chair for this term I want to thank our staff Oversight and Investigations, what great job they have done. They have succeeded in making me look a whole lot smarter than I am, and I am most grateful for their hard work and dedication to all that they have done for our country and specifically for this committee.

I want to remind members that they have 10 business days to submit questions for the record, and I ask the witnesses to agree to answer those as promptly as you can should you receive any written questions.

Again, we thank you, and this subcommittee is adjourned.

[Whereupon, at 11:57 a.m., the subcommittee was adjourned.]